Every Woman's Life FAQ

Questions and Answers:

Q: A radiologist is recommending an MRI for a client with an imaging result of BI-RADS 0. Can we proceed with the MRI?
A: No, all MRI requests must be pre-approved by the state office. The EWL coordinator or case manager is required to email a brief synopsis (excluding identifiable patient information) of the request to the Chronic Disease Clinical Coordinator and the client's imaging reports, office notes, risk model assessment and any other pertinent supporting documentation to the state office. An MRI is not automatically approved because the Radiologist recommends it.

Q: The provider (sub-contracted) is asking for reimbursement above the approved VABCEEDP allowable procedures and relevant CPT codes and fees. Also, the CPT code requested for reimbursement is not listed. What should we do?
A: Although there is some leniency, only approved codes should be reimbursed. If you encounter a CPT code bill for a code not on the list, consult with the state office prior to reimbursement. Reimbursement can never exceed the Medicare rate.

Q: On the CMS.gov web site, there is a quote stating that sometimes hospitals can be paid at the non-facility (higher) rate when the facility is responsible for the cost of providing the staff and supplies. Which circumstance would warrant a facility (hospital) to be reimbursed at the higher non-facility rate?
A: A facility may be allowed to get the higher rate when the facility is providing the entire service (including physician, supplies, and additional staff) and there is no separate provider charge. For instance, a procedure is done at a facility where the provider is employed by that facility and is paid by the facility as a staff employee. The provider would not send a separate bill for the procedure.

Q: Some of our contractors are using a new high risk HPV mRNA test for cervical cancer screening. While this test is typically more expensive than the HR HPV DNA test, can we reimburse at the same rate as the HR HPV DNA test?
A: Yes, the mRNA test may be reimbursed at the same approved rate as the HR HPV DNA test.

Q: Can NBCCEDP funds be used to pay for an Endometrial Biopsy or CPT code 58100 if it is performed due to post-menopausal bleeding?
A: As part of the diagnostic evaluation for abnormal bleeding to rule out cervical cancer, a Pap test should be done. If a recent Pap was completed for abnormal bleeding and was negative but showed endometrial cells in a postmenopausal woman or had atypical glandular cells, you can proceed with an endometrial biopsy for follow up (per ASCCP guidelines). However, if she did not have a Pap test with one of the above results, then EWL funds should **not** be used to reimburse this procedure.

Q: A client had an abnormal pap (ASCUS-H) and a colposcopy with a biopsy result of CIN3. At the time of the abnormal Pap and colposcopy, she had insurance coverage but was not enrolled with the EWL program. Prior to having a loop electrosurgical excision procedure (LEEP) performed the client lost her insurance coverage. Can we refer her to the BCCPTA although we are not submitting an invoice for her?
A: Yes, this woman can be referred to the BCCPTA for treatment once EWL eligibility has been established including verification of treatment providers. Screening and/or diagnostic services must have been rendered by a participating EWL provider or subcontractor. The appropriate EWL forms should be completed and submitted to the state office.

Q: CPT Code 76645 has been eliminated. Since the new breast ultrasound CPT codes 76641 and 76642 are both unilateral, should we expect to see two CPT codes billed if a bilateral ultrasound exam is needed?
A: No, two codes should not be billed for a bilateral ultrasound. For bilateral breast ultrasound, a modifier 50 should be added to either 76641 or 76642 to indicate a bilateral procedure.

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FAQ

Q: Can identifiable client information be sent to EWL central office staff member via email?
A: No. Identifiable information cannot be sent electronically (i.e., name, DOB, address, social security number, etc.). However, clinical synopsis can be emailed as long as the client is not identified. For example, "client had a pap 5/1/2015 with a result of LSIL."

Q: The client had a loop electrosurgical excision procedure (LEEP) performed. Should we record it as a diagnostic or treatment on the cervical screening/diagnostic form?
A: A LEEP is one way to remove abnormal cells from the cervix. If the client has a Colposcopy biopsy result of CIN II or greater the client should be referred to the BCCPTA Medicaid for treatment. If there is not a definitive diagnosis and the provider performs a LEEP as further evaluation then it can be documented as a diagnostic. A LEEP performed as treatment **cannot under any circumstance** be reimbursed with EWL funds.

Q: Can the EWL Case Manager be a non-licensed professional?
A: No, the case manager must be a licensed health care professional (i.e. LPN, RN, NP, etc.). The EWL Coordinator may be non-licensed but not the case manager.

Q: A client received a diagnostic mammogram for a palpable mass. The central office data staff said a diagnostic procedure was not performed. How is this possible?
A: The CDC does not count a diagnostic mammogram as a diagnostic procedure/follow up. Regardless of the CDC recommendation, all EWL providers should follow the current NCCN guidelines for management of women and their symptomatic or imaging findings.

Q: A woman presents to our EWL site and she is enrolled in the ACA or Health Insurance Marketplace but cannot afford her deductible. Are we able to enroll her into EWL and provide assistance?
A: No. At the current time, only uninsured women are eligible for EWL. VABCCEDP no longer serves women who are underinsured. These women should be referred to other community resources for assistance.

Q: We aren't meeting our 50 and over performance indicator. What should we do to improve in this area?
A: Market your local EWL program. Use a tracking system that will assist you in monitoring this indicator. Reach out to local churches, YMCA's, libraries, etc., and ask permission to place informational program brochures at their location. The central office will do what it can to assist in overarching state wide marketing; however, each EWL provider site will need to reach out to its own community to promote the program.

Q: An enrolled client's pathology report revealed Pseudoangiomatous Stromal Hyperplasia (PASH). Can we refer her to the BCCPTA Medicaid if an excision is warranted?
A: No. PASH is a benign histology and **is not** a pre-cancerous condition. Excision **is not** warranted unless discordant from the mammographic finding. Refer to the VABCCEDP Allowable Procedures & Relevant CPT Codes and Fees listing for approved excisional breast lesion codes.

Q: As a EWL provider, can we conduct or participate in fundraisers?
A: The central office and local health districts are not allowed to accept donations or fundraise. Private providers may fundraise and accept donations. Private providers may use the raised funds for direct care services or administrative needs.